BEFORE THE KANSAS WORKERS COMPENSATION APPEALS BOARD

KEVIN D. EVANS	)	
Claimant	)	
V.	)	
	)	Docket No. 1,062,821
CESSNA AIRCRAFT CO.	)	
Self-Insured Respondent	)	

ORDER

Respondent requested review of the August 7, 2015, Award by Administrative Law Judge (ALJ) Thomas Klein. The Board heard oral argument on December 15, 2015.

APPEARANCES

Jeffrey K. Cooper, of Topeka, Kansas appeared for the claimant. Dallas L. Rakestraw, of Wichita, Kansas, appeared for self-insured respondent.

RECORD AND STIPULATIONS

The Board has considered the record and adopted the stipulations listed in the Award.

ISSUES

The ALJ relied on the opinions of board certified orthopedic surgeon, Daniel J. Prohaska, M.D., and board certified physical medicine and rehabilitation specialist, Pedro A. Murati, M.D., to award claimant a combined permanent partial functional impairment to the body as a whole of 17 percent for his October 7, 2011, work-related accident. The ALJ found the lumbar surgery performed by board certified neurological surgeon John R. Dickerson, M.D., was reasonable and medically necessary to cure and relieve claimant's left leg pain. The ALJ determined that no physician testified the left leg pain was not a consequence of claimant's accident, or that the accident was not the prevailing factor in the claimant's need for medical treatment. The ALJ ordered all the bills from Dr. Dickerson's surgery be paid as authorized medical treatment, pursuant to the medical fee schedule.

The ALJ declined to order temporary total disability compensation (TTD) as a result of the surgery. The ALJ further found claimant will need future medical care in the form of at least yearly check ups for his lumbar spine and shoulders.

Respondent appeals, arguing claimant is entitled to no more than a 7 percent permanent partial whole body functional impairment for the lumbar spine and bilateral shoulders (5 percent to the lumbar spine and 2 percent for each shoulder), therefore the Award should be modified. Respondent also argues it should not be responsible for the unauthorized expenses associated with surgery claimant had on his back with Dr. Dickerson, as claimant sought treatment on his own without seeking prior authorization or asking for a change of physician. Further, because it was not reasonably necessary to cure and relieve the effects of claimant's injury the ALJ's award of payment of those expenses should be reversed.

Claimant argues the Board should adopt the findings of Dr. Murati, who opined claimant has a 37 percent permanent partial whole person functional impairment. Claimant contends it was error not to include impairment ratings for his thoracic spine and neck. Claimant asserts the ALJ's findings regarding Dr. Dickerson's surgery should be upheld and the award of payment of his surgical treatment as authorized medical should be affirmed.

Originally, claimant contended TTD benefits were improperly calculated and should be modified to reflect the actual time spent totally and temporarily disabled, which, claimant alleges, would be 19.71 weeks. However, at oral argument to the Board, claimant advised the issue regarding the payment of additional TTD compensation was no longer before the Board. Therefore, the award of .71 weeks of TTD at the weekly rate of $349.05 is affirmed.

The issues on appeal are:

1. What is the nature and extent of claimant's injuries and disability?

2. Is claimant entitled to payment of medical treatment/bills incurred after seeking medical care on his own, *i.e.* should Dr. Dickerson's medical treatment, including surgery, be ordered paid as authorized medical care?

3. Is claimant entitled to future medical treatment?

FINDINGS OF FACT

Claimant has been certified as an airframe and power plant technician for 25 years. He has worked for Cessna for 19 years. In October 2011, he oversaw repairs of the aircraft. Claimant continues to work for Cessna.

On October 7, 2011, claimant fell off of a stool. He testified, "I was having a meeting with the shift previous to me as to the status on an airplane, and I got some sealer on my hands, so I turned to my left, I was sitting on a stool, and grabbed a wipe to wipe it off. And when I turned back, the next thing I know I'm on my back side."[1]

Claimant's low back, buttocks, back and elbows struck the floor. Claimant had some pain, but was able to work his regular shift. As time went on, claimant's pain worsened. He initially had pain on the left side of his low back that radiated into his buttock, into his groin and down his leg, through his knee and into his toes. He also had pain in his shoulders and elbows. Claimant received epidural injections in his low back with Dr. Estivo. They provided no lasting benefit. Claimant received treatment for his shoulders with Dr. Prohaska. He had surgery on his left shoulder, but he had no benefit from it, and for that reason he declined treatment for the right shoulder.

Claimant admits to low back problems prior to October 7, 2011. Claimant had a prior injury to his low back in 1988 while in the employment of Oxygen Service Company. He had treatment and was referred to vocational rehabilitation. Claimant filed a claim for this injury, but ultimately dropped it. In 2003 or 2004, he had a back strain. He received physical therapy and was under treatment for several months, after which the back strain resolved. He denies any problems with his left leg before October 7, 2011. He does not remember anything about his right leg, but claimant's counsel pointed out the claimant also complained of right lower extremity symptoms from the 2004 incident. Claimant had an FCE in January 2005 and was assigned permanent restrictions. Respondent changed claimant's job to accommodate the restrictions.

In April 2012, claimant had a flare-up of his symptoms from the October 2011 incident while working at home and went to his family doctor for treatment. Claimant testified he had been doing yard work which caused him to be pretty sore. He went to Health Services and was referred to his family doctor after being told there was no record of any back injury. His family doctor concluded claimant had an aggravation of a preexisting condition. Claimant received treatment for his back complaints with his family physician after the April 2012 incident.

Claimant met with Daniel J. Prohaska, M.D., at respondent's request, on November 10, 2011. His complaints included bilateral shoulder pain, with the right being slightly worse than the left. Claimant denied any prior shoulder problems. He reported his pain increased with reaching away from his body, above his head or behind his back. Claimant also reported some stiffness, loss of motion, swelling, numbness and tingling in his shoulders since the accident on October 7, 2011. Claimant underwent physical therapy, which did not help with his pain. Rest and ice made the symptoms better. Dr. Prohaska diagnosed bilateral shoulder injury and coracoid traumatic impingement.

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[1] R.H. Trans. at 12-13.

Dr. Prohaska opined that "based on his fall on extended elbows I think he is having more of a contusion or anterior capsule strain."[2] He recommended conservative treatment with anti-inflammatory medication and physical therapy. Claimant was allowed to return to work with restrictions of no lifting over 25 pounds and no work over chest height.

Claimant met with Dr. Prohaska again on December 22, 2011, reporting no improvement and continued pain in his shoulders with the left being much worse than the right this time. Dr. Prohaska found no improvement in claimant's shoulders with the same coracoid traumatic impingement diagnosis. He recommended claimant have a subacromial injection in the left shoulder and more physical therapy. Claimant was returned to modified duty of no lifting over 25 pounds bilaterally and no work over chest height.

Claimant met with Dr. Prohaska again on February 2, 2012, for followup of his shoulder injuries. Claimant reported being 30 percent better which he attributed to the injection he received in his left shoulder. Claimant presented a new complaint of intermittent pain with reaching behind his back. Claimant was returned to modified duty of no lifting over 30 pounds and no overhead work.

On March 29, 2012, claimant continued to have bilateral shoulder pain, but Dr. Prohaska assured claimant he was making good progress. Claimant's shoulders were again injected. Claimant returned to modified duty of no lifting over 30 pounds and no overhead work.

By May 10, 2012, claimant had no improvement from the prescribed treatment at the time. Dr. Prohaska offered surgery as a treatment option. Claimant was restricted for both shoulders to no lifting over 30 pounds and no overhead work.

On May 23, 2012, claimant had surgery consisting of a left shoulder coracoid decompression for impingement. Dr. Prohaska indicated it appeared the accident increased claimant's impingement.

On June 1, 2012, eight days post left shoulder surgery, claimant reported he was doing no better. Claimant also complained of some weakness, stiffness, loss of motion, numbness and tingling. Dr. Prohaska instructed claimant to continue with physical therapy and home exercise and to return to modified duty with restrictions of no lifting over 5 pounds and no overhead work.

By July 12, 2012, two months post left shoulder surgery, claimant reported being 20 percent better, but continued to complain of bilateral shoulder pain. Claimant also complained of some weakness, stiffness, loss of motion, numbness and tingling. He

[2] Prohaska Depo., Ex. 2 at 36 (Dr. Prohaska's Nov. 10, 2011, report).

reported the left shoulder being worse than the right. He was instructed to continue with home exercise and placed on modified duty with restriction for both shoulders of no lifting over 30 pounds, no overhead work over an 1 hour per half shift with 3 hours between overhead work.

Claimant's bilateral shoulder complaints continued and on August 23, 2012, Dr. Prohaska recommended claimant continue with physical therapy, specifically ASTYM (augmented soft tissue massage) to try and break down any thickening or potentially any fibrosis that could have occurred from the chronic inflammation in the anterior shoulder region. Claimant was placed on modified duty with restriction for both shoulders of no lifting over 30 pounds, no overhead work over one hour per half shift with 3 hours between overhead work.

By October 4, 2012, claimant still was no better. This was 4½ months post surgery on the left shoulder. Claimant was found to be at maximum medical improvement (MMI) and a Functional Capacity Evaluation (FCE) was recommended to determine final work restrictions. Claimant was placed on modified duty with restriction for both shoulders of no lifting over 30 pounds, no overhead work over one hour per half shift with 3 hours between overhead work. Dr. Prohaska also diagnosed right shoulder impingement.

Claimant had an FCE on October 18, 2012, at which time it was determined claimant could work at the light to medium physical demand level. He was assigned restrictions based on an 8 hour work day of: occasional pushing with the right and left; occasional reaching above the shoulder with the left, frequently with the right; frequently crawl, pull, reach forward, reach above the shoulder, forceful grasping with rotation, fine hand manipulation, simple grasping with the right and left; frequently reach above the shoulder with the right; constantly forceful grasping with the right and left, and constantly pinching with the right and left. Lifting from floor to waist, occasionally 40 pounds, frequently 20 pounds and constantly 8 pounds; lift from the floor to at/above the shoulder, occasionally 20 pounds, frequently 10 pounds and constantly 4 pounds; carrying on level surfaces/stairs, occasionally 40 pounds, frequently 20 pounds and constantly 8 pounds; pushing force, 40 pounds, frequently 20 pounds and constantly 8 pounds; pulling force, 40 pounds, frequently 20 pounds and constantly 8 pounds.

Dr. Prohaska opined that since claimant failed to make any progress with the left shoulder with surgery, he did not recommend surgery on the right shoulder. He indicated surgery should have resolved claimant's impingement symptoms and when it did not, the FCE was the next step to get claimant in a position where his symptoms were not aggravated by activity.

Upon request, Dr. Prohaska opined claimant had a 2 percent impairment to each upper extremity, which converts to 1 percent to the body as a whole for each upper extremity, for slight deficit in range of motion. Combined, the impairments equal 2 percent to the body as a whole, based on the 4th Edition of the AMA *Guides*.

At respondent's request claimant met with board certified orthopedic surgeon, John P. Estivo, D.O., on December 5, 2011, for examination and treatment of the lumbar spine in relation to the injury on October 7, 2011. Claimant reported lumbar spine pain and right shoulder and right elbow discomfort after a fall. Claimant reported that the lumbar spine pain radiated into his left foot occasionally, with numbness and tingling in the first and second toes of his left foot. Claimant admitted a history of a previous lumbar spine injury seven or eight years prior. Claimant did not complain of thoracic or cervical spine pain.

Dr. Estivo examined claimant and found tenderness to palpation on the left side of the lumbar spine with mild tenderness throughout range of motion. The rest of the examination was normal. Dr. Estivo also examined the cervical and thoracic spines and found them to be normal. Dr. Estivo diagnosed lumbar spine strain, a bulging disk at L4-5 and preexisting degenerative age-related disk disease to the lumbar spine. He recommended an epidural injection to the lumbar spine and physical therapy for the lumbar spine, three times a week for a month. The injection was recommended to treat nerve root irritation at L4-5 caused by the bulging disk and neuroforminal narrowing. Dr. Estivo also recommended temporary work restrictions of no lifting more than 20 pounds and no constant bending or twisting.

Claimant met with Dr. Estivo again on December 29, 2011, after receiving an epidural injection to the lumbar spine. Claimant continued to have occasional lumbar spine discomfort and numbness in his left foot. He had a non-antalgic gait. Claimant's cervical spine had full range of motion without muscle spasm or discomfort. Claimant reported some tingling in the first and second toes of his left foot, but no motor deficits were found. Claimant was diagnosed with lumbar spine strain and a bulging disk at L4-5. Claimant had no thoracic spine complaints. Dr. Estivo recommended a second epidural injection at L4-5 and continued physical therapy. Claimant was allowed to work with temporary restrictions of no lifting over 20 pounds and no constant bending or twisting.

Claimant met with Dr. Estivo again on January 18, 2012, after claimant's second lumbar spine epidural injection. Claimant continued to have lumbar spine discomfort that would come and go, with occasional left leg pain and numbness in his left foot, but it was less. He also had slight numbness in his right great toe. Claimant did not complain of cervical or thoracic spine discomfort. Claimant was examined and his previous diagnosis had not changed. Dr. Estivo recommended a third epidural injection to the lumbar spine at L4-5 and continued physical therapy. Claimant was allowed to work with temporary restrictions of no lifting over 20 pounds and no constant bending or twisting.

Claimant met with Dr. Estivo on February 22, 2012, after his third epidural injection. Claimant reported no significant improvement from the injections. He reported pain in his left leg, numbness in his great toe and occasional numbness in his right leg. He had a non-antalgic gait and had full range of motion without spasm or discomfort in the cervical spine. Claimant had no upper extremity complaints. Dr. Estivo diagnosed lumbar

radiculopathy, preexisting age-related degenerative disk disease to the lumbar spine and lumbar spine strain. This diagnosis was slightly different from his prior diagnoses. Dr. Estivo recommended claimant maintain temporary work restrictions of no lifting over 20 pounds and no constant bending or twisting. He also ordered an NCS/EMG of the lower extremities and a CT myelogram of the lumbar spine.

Claimant met with Dr. Estivo again on March 7, 2012, after the myelogram CT scan and the NCS/EMG. The tests found claimant to have a degenerative bulging disk at L4-5. There was no nerve impingement or spinal canal stenosis. Claimant did have some lumbar spine discomfort, claimed right and left leg pain and numbness to the right great toe, all that came and went. Claimant did not have cervical or thoracic spine complaints.

Dr. Estivo examined claimant and found everything to be normal. He opined claimant had a lumbar spine strain and preexisting age-related degenerative disk disease to the lumbar spine. Dr. Estivo indicated the radiculopathy diagnosis was removed because there was no evidence of radiculopathy from the myelogram/CT scan or the NCS/EMG. Dr. Estivo opined claimant did not require any further medical treatment in relation to the back injury and found claimant to be at MMI. He assigned claimant a 5 percent whole person impairment and determined claimant's preexisting degenerative disk disease was not related to the October 7, 2011, injury claim. However, he testified the lumbar strain was related to the October injury claim. He recommended a 50 pound permanent lifting restriction and recommended claimant continue with physical therapy on his own at home. Claimant was released from care. Dr. Estivo did not believe claimant to be a surgical candidate.

Dr. Estivo did not put any specific focus on claimant's shoulders, because he was asked to focus on the lumbar spine and because claimant never complained of anything other than the low back.

Claimant met with John R. Dickerson, M.D., on August 23, 2012, upon referral from his family physician, Scott Hanes, M.D. Claimant reported back pain and persistent left leg pain to the point where prolonged standing, walking or sitting caused him excruciating pain in the buttock, hamstrings, calf down to the heel and the bottom of the foot. Claimant also had decreased sensation to pinprick on the soles of his feet and some decreased Achilles reflex on the left compared to the right. Dr. Dickerson felt claimant had significant lumbosacral spine pain with flexion and extension and sacroiliac pain. Dr. Dickerson felt claimant might see some improvement with an L5-S1 laminotomy for nerve root decompression. Dr. Dickerson did not have available to him the medical records of the other physicians who had determined claimant was not a candidate for surgery.

On May 15, 2014, claimant returned to Dr. Dickerson, reporting lower back pain and leg pain, with insomnia due to the pain. The majority of claimant's pain was severe left leg pain. The doctor diagnosed lower back pain, lumbar disc degeneration and orthopedic disorders of the spine, with nerve root compression. Dr. Dickerson felt claimant would

benefit from a left-sided L4-5 foraminotomy with microdiskectomy and a L3-4 laminotomy. Claimant submitted a request to his health care insurance company for permission to proceed with the surgery. This permission was granted in a letter dated June 9, 2014.

Dr. Dickerson performed surgery on June 20, 2014, consisting of a left L3-4, L4-5 and L5-S1 foraminotomy with microdiscectomies at L3-4 and L4-5 and a left L3 and L5 partial laminotomy. Dr. Dickerson performed another surgery on June 27, 2014, involving a lumbar wound exploration and revision with repair of a CSF (incision) leak. These surgeries were not approved by respondent or its workers compensation insurance carrier.

At his July 10, 2014, post surgery visit, Dr. Dickerson diagnosed claimant with lumbar disc degeneration, orthopedic disorders of the spine and nerve root compression. Claimant was told losing weight may help improve his symptoms.

At his August 14, 2014, post surgery visit, claimant was diagnosed with lumbar disc degeneration, orthopedic disorders of the spine, nerve root compression and lower back pain. He was again told losing weight may help improve his symptoms.

On October 9, 2014, claimant reported overall improvement of 50 - 75 percent, post surgery. He continued to have left lumbar back pain, left knee, hamstring and heel pain. He also reported numbness and tingling in his great left toe. Dr. Dickerson diagnosed lumbar disc degeneration, orthopedic disorders of the spine, nerve root compression and lower back pain.

On October 30, 2014, claimant continued to show improvement and was released to work with a 40 pound lifting restriction. When asked if he felt the surgery he recommended and ultimately performed was causally related to the October 7, 2011, event, Dr. Dickerson testified claimant's pain down his leg was related to the disc herniation, which started with the fall at work and that it was related to that accident.

Dr. Dickerson testified he had no documentation of claimant's back problems before the October 2011 work event and normally that would be important to know in terms of causation, but he was trying to figure out if he could help claimant and was not evaluating for causation. He did ask claimant about prior problems, but claimant did not report those prior problems to him.

Dr. Dickerson was questioned about his knowledge of claimant's prior back problems:

> Q. So how did we get from that MRI in 2011 saying no true disc herniations to your report in August of 2012 where it says he has disc herniations?
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> A. Lots of times we disagree with radiologists. We read -- I read on my own firms, as do all neurosurgeons.

Q. Essentially, Mr. Evans wanted back surgery and you were willing to do it, true?

A. No, that's not true.

Q. Did he want back surgery?

A. He wanted to be better. I don't know that he wanted back surgery. He had already been through epidural steroid injections and physical therapy and he was kind of at the end of his rope. I mean, all of this was on his private insurance and he was paying for it, so he didn't really -- he couldn't stand, he couldn't walk due to his left leg pain and so, I mean, what else was he going to do, lay on his couch for the rest of his life? He tried everything that could possibly be tried at that point. I disagreed with the radiologist's reading for that. We did surgery for him, he's better and he can walk. He has no leg pain.

Q. He's 70 percent better on his own report.

A. And the 30 percent was the numbness which will resolve with time as the nerve heals, probably due to the delay in his treatment.

Q. Were you aware that because of a prior back problem, he was on permanent restrictions for a prior back injury and treatment?

A. Not that I documented.[3]

Claimant met with board certified neurological surgeon, Paul S. Stein, M.D., on August 15, 2013, for a court-ordered independent medical examination (IME). Claimant complained of low back pain, bilateral shoulder pain, greater on the left and intermittent numbness and tingling into the left lower extremity, with occasional numbness in the toes on the right foot. Claimant related his pain to the work injury. Dr. Stein opined there was no evidence on the MRI or myelogram of disc herniation, but he could not rule out some impingement of the right SI nerve root perhaps from degenerative change or narrowing.

Dr. Stein examined claimant and did not feel there was a definitive diagnosis for claimant's persistent shoulder discomfort. The left shoulder arthroscopy performed by Dr. Prohaska did not provide much, if any, reported benefit. He had no recommendation for further evaluation or treatment of the shoulders and found claimant to be at MMI for his shoulders. He determined the incident at work was the primary or prevailing factor causing the shoulder symptoms but no definitive pathologic or anatomic diagnosis had been made to explain claimant's symptoms.

Dr. Stein determined that, despite the previous history, it was likely the current lumbar spine symptoms are due to an aggravation of preexisting degenerative disease, the

[3] Dickerson Depo. at 29-30.

prevailing factor in claimant's symptoms being the October 7, 2011, accident at work. He opined that surgery was not a good option for claimant, but a diskogram would be reasonable to determine if a diskectomy or fusion at only L5-S1 would be an option. Claimant was found to be at MMI for the lumbar spine.

After claimant underwent a lumbar diskogram, Dr. Stein provided a followup report on October 22, 2013. Claimant was diagnosed with degenerative change at L2-3, L3-4 and L4-5. Given the multiple positive levels, Dr. Stein still could not recommend surgery and again found claimant to be at MMI. He deferred rating claimant's shoulders to Dr. Prohaska and rated the lower back with a 5 percent impairment to the body as a whole under the DRE Lumbosacral Category II.

Dr. Stein indicated that even though claimant claims his back is significantly better from back surgery with Dr. Dickerson, that is not an indication that the surgery was successful. He testified:

> A. . . . I think there's a significant placebo effect. What would convince me was a patient that walked in here four months after surgery. "I'm 95% better, I'm ready to go back to full duty work activity, I need no medication." Instead of having a patient come in saying he's 60, 70% better. The patient will say, "Yes, I am better. I still have this, I still have that, I still need this, I can't do that and we need to make a settlement." And that's where it's going to wind up.[4]

Claimant met with Dr. Pedro A. Murati, M.D., on December 12, 2013, for an examination, at the request of his attorney. Claimant had complaints of low back pain numbness, tingling and pain in his left leg, groin pain, soreness in both shoulders, aching in both elbows occasionally, aching in his right knee and neck pain. Claimant also indicated that since his discogram, he has had aching in his right knee and numbness in his toes.

Dr. Murati examined claimant and diagnosed status post left shoulder coracoid decompression; right rotator cuff sprain; cervical radiculopathy; myofascial pain syndrome of the bilateral shoulder girdles extending into the cervical and thoracic paraspinals and low back pain with signs of radiculopathy. He opined that the diagnoses are within all reasonable medical probability a direct result from the October 7, 2011, work injury. Dr. Murati recommended at least yearly follow-up appointments for claimant's low back, bilateral shoulders, upper back and neck.

Dr. Murati assigned claimant permanent restrictions in an 8 hour work day of no bending, crouching, or stooping; no climbing ladders; no crawling; no above the shoulder work with the right or left; no lifting, carrying, pushing or pulling more than 20 pounds

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[4] Stein Depo. at 29.

occasionally and 10 pounds frequently; no working more than 24 inches from the body with the right or left; alternate sitting, standing and walking and avoid trunk twist.

Dr. Murati assigned a 10 percent whole person impairment for low back pain with signs of radiculopathy; 5 percent whole person impairment for myofascial pain syndrome affecting the thoracic paraspinals; 15 percent whole person impairment for neck pain; 7 percent right upper extremity impairment (4 percent whole person impairment) for loss of range of motion of the right shoulder; 8 percent left upper extremity impairment for loss of range of motion of the left shoulder; 10 percent left upper extremity impairment for status post subacromial decompression. The left upper extremity impairments combine for a 17 percent left upper extremity impairment and convert to a 10 percent whole person impairment. Dr. Murati combined the whole person impairments for a 37 percent whole person impairment.

Claimant met with board certified internal medicine specialist, Chris D. Fevurly, M.D., for an examination, at respondent's request, on December 18, 2014. Claimant reported improvement in his back pain post surgery in June 2014. He continued to have pain in his right leg and numbness and tingling in both feet and toes. He also had associated right heel pain and persistent bilateral shoulder pain, left groin pain three to four times a week, bilateral knee aches on occasion, left medial elbow pain once or twice a week, neck pain and soreness and headaches.

Dr. Fevurly examined claimant and diagnosed mild bilateral shoulder impingement with rotator cuff tendinopathy; chronic regional low back pain without current radiculopathy; depressive disorder and anxiety disorder; no evidence of current cervical radiculopathy or myelopathy and a preexisting history of polyarthralgias.

Dr. Fevurly opined the work fall aggravated preexisting degenerative changes in claimant's bilateral shoulders and lumbar spine resulting in chronic shoulder pain and low back pain with equivocal reports of left leg radicular pain over the past three years. He found the prevailing factor for the shoulder and low back pain to be the work fall on October 7, 2011. He indicated there was no medical report to support a cervicothoracic injury or other significant joint related injuries in any other anatomical locations as a result of the fall. The only mention of claimant reporting cervical and thoracic spine complaints was in Dr. Murati's report.

Dr. Fevurly noted claimant reached MMI for the shoulders and low back on November 1, 2013, and despite that, claimant went forward with a lumbar spine decompression surgery in June 2014. Dr. Fevurly noted the surgery was done under claimant's personal health insurance.

Dr. Fevurly agreed with Dr. Prohaska, finding claimant to have a 2 percent upper extremity impairment in each shoulder for chronic impingement complaints. He also assessed claimant a 5 percent whole person impairment for the lumbar spine. Combined,

claimant's impairment is 9 percent to the body as a whole. Claimant was restricted to light to medium work with occasional lifting up to 40 pounds, frequent lifting up to 20 pounds to chest level, with overhead work limited to an occasional basis with either arm. Dr. Fevurly did not feel claimant was in need of any further treatment for the shoulders or the lumbar spine.

PRINCIPLES OF LAW AND ANALYSIS

K.S.A. 2011 Supp. 44-501b(b)(c) states:

> (b) If in any employment to which the workers compensation act applies, an employee suffers personal injury by accident, repetitive trauma or occupational disease arising out of and in the course of employment, the employer shall be liable to pay compensation to the employee in accordance with and subject to the provisions of the workers compensation act.
> (c) The burden of proof shall be on the claimant to establish the claimant's right to an award of compensation and to prove the various conditions on which the claimant's right depends. In determining whether the claimant has satisfied this burden of proof, the trier of fact shall consider the whole record.

K.S.A. 2011 Supp. 44-508(h) states:

> (h) "Burden of proof" means the burden of a party to persuade the trier of facts by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record unless a higher burden of proof is specifically required by this act.

K.S.A. 2011 Supp. 44-510e(a)(2)(A)(B)(C) states:

> (2) (A) Permanent partial general disability exists when the employee is disabled in a manner which is partial in character and permanent in quality and which is not covered by the schedule in K.S.A. 44-510d, and amendments thereto. Compensation for permanent partial general disability shall also be paid as provided in this section where an injury results in:
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> (i) The loss of or loss of use of a shoulder, arm, forearm or hand of one upper extremity, combined with the loss of or loss of use of a shoulder, arm, forearm or hand of the other upper extremity;
> (ii) the loss of or loss of use of a leg, lower leg or foot of one lower extremity, combined with the loss of or loss of use of a leg, lower leg or foot of the other lower extremity; or
> (iii) the loss of or loss of use of both eyes.
> (B) The extent of permanent partial general disability shall be the percentage of functional impairment the employee sustained on account of the injury as established by competent medical evidence and based on the fourth edition of the

> American medical association guides to the evaluation of permanent impairment, if the impairment is contained therein.
> (C) An employee may be eligible to receive permanent partial general disability compensation in excess of the percentage of functional impairment ("work disability") if:
> (i) The percentage of functional impairment determined to be caused solely by the injury exceeds 7½% to the body as a whole or the overall functional impairment is equal to or exceeds 10% to the body as a whole in cases where there is preexisting functional impairment; and
> (ii) the employee sustained a post-injury wage loss, as defined in subsection (a)(2)(E) of K.S.A. 44-510e, and amendments thereto, of at least 10% which is directly attributable to the work injury and not to other causes or factors.
> In such cases, the extent of work disability is determined by averaging together the percentage of post-injury task loss demonstrated by the employee to be caused by the injury and the percentage of post-injury wage loss demonstrated by the employee to be caused by the injury.

Claimant alleges injuries to multiple parts of his body. The ALJ determined claimant failed to prove injury to either his cervical spine or his thoracic spine. The Board agrees and affirms the denial of benefits for those alleged injuries.

However, claimant did suffer injuries to his shoulders and lumbar spine. This is supported by medical records from claimant's treating physicians as well as the experts hired by each party and the IME ordered by the ALJ. The medical experts disagree on the extent of claimant's injuries and whether those injuries stem from the October 7, 2011, accident. But all agree claimant has, at the very least, significant degeneration in his lumbar spine, with some health care professionals diagnosing bulging and/or herniated discs as well. The medical opinions are divided as to whether claimant's lumbar problems stem from the work-related accident or the long term accumulation of degenerative problems. The Board finds, at the very least, claimant suffered additional injuries to his lumbar spine when the chair collapsed under him. The determination by the ALJ that claimant suffered a 10 percent functional whole person impairment to the lumbar spine from this accident is supported by this record and is adopted by the Board.

Likewise, claimant suffered injuries to his shoulders resulting from the accident. Again, the record contains conflicting ratings regarding the permanency of the injuries to claimant's shoulders. The ALJ found claimant suffered an 8 percent whole person impairment for the combined shoulders and the Board agrees. The lumbar and shoulder ratings combine for a total whole body impairment of 17 percent. The Award for claimant's functional impairment is affirmed.

K.S.A. 2011 Supp. 44-510h(a)(b)(2) states:

> (a) It shall be the duty of the employer to provide the services of a health care provider, and such medical, surgical and hospital treatment, including nursing,

> medicines, medical and surgical supplies, ambulance, crutches, apparatus and transportation to and from the home of the injured employee to a place outside the community in which such employee resides, and within such community if the director, in the director's discretion, so orders, including transportation expenses computed in accordance with subsection (a) of K.S.A. 44-515, and amendments thereto, as may be reasonably necessary to cure and relieve the employee from the effects of the injury.
> (b) . . .
> (2) Without application or approval, an employee may consult a health care provider of the employee's choice for the purpose of examination, diagnosis or treatment, but the employer shall only be liable for the fees and charges of such health care provider up to a total amount of $500. The amount allowed for such examination, diagnosis or treatment shall not be used to obtain a functional impairment rating. Any medical opinion obtained in violation of this prohibition shall not be admissible in any claim proceedings under the workers compensation act.

The Board must next determine whether the surgery performed on claimant's low back by Dr. Dickerson was authorized or unauthorized. The ALJ found the surgery to be reasonably and medically necessary to cure and relieve the claimant's left leg pain. The Board agrees. However, this does not answer the question as to whether the surgery was authorized or whether claimant is limited to the $500 unauthorized statutory allowance. Both the Board and the appellate courts have dealt with this question. In *Thompson*[5], the Court of Appeals reversed the Board's determination that the ALJ erred in refusing to allow Thompson's hospital charges for emergency room visits as authorized medical expenses. This was despite the fact the visits occurred during hours when the doctors' offices were not open and Thompson felt she could not wait until the following morning to consult the doctor. The Court noted that while the statute establishes an employer's general duty to provide medical care for an injured employee, there is no provision requiring an employer or an employers insurance carrier to pay for medical expenses incurred solely at the employee's discretion. In *Thompson*, the claimant was provided with health care by her employer.

The Board is mindful of the Kansas Supreme Court's decision in *Saylor*[6], where the Court affirmed the Board's compensation award for unauthorized medical expenses that exceeded the $500 limit because the employer possessed knowledge of the work-related injury, but provided no medical care.[7] However, this matter is more analogous with *Thompson,* as this respondent has provided medical care for claimant regularly since the accident.

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[5] *Thompson v. Hasty Awards, Inc.*, No. 106,359, 277 P.3d 447 (Court of Appeals unpublished opinion filed May 25, 2012).

[6] *Saylor v. Westar Energy, Inc.*, 292 Kan. 610, 256 P.3d 828 (2011).

[7] See K.S.A. 44-510j(h).

The Board determines claimant's surgery by Dr. Dickerson was unauthorized. Claimant acknowledged he made no attempt to obtain authorization prior to the surgery, and even though the medical treatment may have been reasonable and necessary, and somewhat successful in relieving some of claimant's symptoms, the failure by claimant to obtain authorization is fatal to this issue. The Board finds the award of medical benefits beyond the $500 statutory unauthorized medical allowance for the surgery performed by Dr. Dickerson is error and is reversed. Claimant is limited to the $500 statutory unauthorized medical allowance under K.S.A. 2011 Supp. 44-510h(b)(2) for the surgical treatment provided by Dr. Dickerson.

The Board agrees that claimant should be entitled to future medical treatment upon application to and approval by the Director. Claimant suffers ongoing physical problems which will likely necessitate future medical care.

CONCLUSIONS

Having reviewed the entire evidentiary file contained herein, the Board finds the Award of the ALJ should be modified to reverse the award of unauthorized medical allowance exceeding the $500 statutory limit, and affirmed with regard to the permanent partial whole person functional impairment of 17 percent. In all other regards, the Award of the ALJ is affirmed insofar as it does not contradict the findings and conclusions contained herein.

AWARD

WHEREFORE, it is the finding, decision and order of the Board that the Award of Administrative Law Judge Thomas Klein dated August 7, 2015, is reversed with regard to the $500 unauthorized medical allowance, but affirmed in all other regards, insofar as it does not contradict the findings and conclusions contained herein.

IT IS SO ORDERED.

Dated this _____ day of January, 2016.

_____
BOARD MEMBER

_____
BOARD MEMBER

_____
BOARD MEMBER

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Thomas Klein, Administrative Law Judge